OKLAHOMA'S 2016 EXCHANGE PLANS

Potential Size of Exchange Market: **About 424,000 Oklahoma residents.**[1]

Improving Exchange Coverage in Oklahoma

While states typically play the primary role in reviewing health plans, plans in Oklahoma are reviewed by the federal government for compliance with the Affordable Care Act. Oklahoma has the opportunity to take a larger role in reviewing plans and could protect its residents through the following actions:

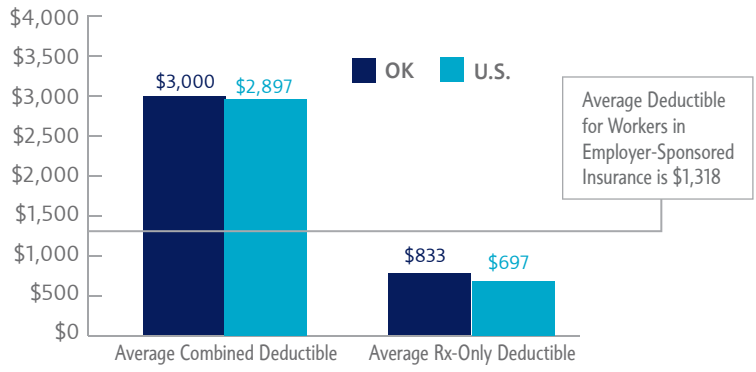
- Enforcing non-discrimination requirements, which apply to benefit design and provider networks; and
- Advocating to CMS for a healthcare.gov website that allows for consumers to compare plans using personalized out-of-pocket cost calculations that reflect plan formularies and provider networks.

Key Facts about 2016 Health Plans in the Oklahoma Exchange:

Deductibles

- Exchange plan coverage is supposed to be consistent with employer-sponsored insurance[2]—the vast majority of which covers prescription drugs immediately.[3]
- In contrast, most exchange plans require that patients either meet a combined deductible for all medical spending—including prescriptions—or have a separate deductible just for prescription medicines. In Oklahoma, 63% of silver plans have a combined deductible, the same as the national average.

Fig. 1: Average Annual Deductibles in Silver Plans: Oklahoma Plans Compared to U.S. Average[4]



Cost Sharing

- Prescription drug cost sharing is often a monthly expense for those with a chronic condition. Cost sharing for medicines can quickly become burdensome for those with high monthly costs.
- Coinsurance generally becomes more common on higher cost sharing tiers.
- In Oklahoma, 100% of plans require copays for preferred brand drugs and those copays average $48. For specialty tier medicines in the Oklahoma exchange, coinsurance is required in 100% of cases and the average coinsurance is 30%.[5]
- Patients under 250% of poverty (about $30,000 for an individual) in exchanges typically qualify for cost sharing subsidies that lower their out-of-pocket costs for silver plans. However, plans have flexibility in how they implement these subsidies, and many plans still have coinsurance levels of more than 30% for higher formulary tiers.[6]

Prescription Drug Coverage in Oklahoma 2016

Health plans on Oklahoma's Health Insurance Exchange are required to cover "Essential Health Benefits" established by federal regulation. Prescription drug benefits are evaluated in comparison to Oklahoma's benchmark health plan, which sets the standard for how many medicines exchange plans must include on their formularies. Under the counting rules defined by federal regulation, Oklahoma's benchmark plan governing 2016 plans covers 88% of medicines that were available when the benchmarks were originally selected. Starting in 2017, plans will have to meet a new benchmark that covers 85% of drugs that were available when these benchmarks were selected.[7] The regulations allow health plans significant leeway in designing formularies to meet a state's benchmark standard. It is important that states review formularies for compliance with established benchmarks and non-discrimination protections because current federal rules for "counting" prescription drug coverage may allow plans to effectively cover fewer drugs than a state's benchmark and typical employer plans.

State review of exchange plan formularies is important because:

- Federal count-based standards related to the number of medicines a plan must cover do not extend to cost sharing. Even if a medicine is covered, it may still be unaffordable. If therapeutic alternatives are not available on a lower cost sharing tier, the benefit design may be discriminatory.
- Federal counting rules do not provide an incentive to cover combination therapies and extended release medicines.[8] These medicines play an important role in patients sticking to and benefiting from the treatments they need.
- There are no rules to ensure consistent coverage or counting of medicines typically included in the medical benefit—these medicines often treat serious conditions such as cancer and neurologic diseases.

Based on an analysis of actual 2016 exchange plan formulary information in Oklahoma, the following key findings are of particular importance to Oklahoma residents:[9]

An average of **90%** of brand medicines are covered across a range of key drug classes in the Oklahoma exchange. The national average is **82%** of brand medicines covered in exchange plans.

An average of **44%** of plans in the Oklahoma exchange placed all of their drugs in at least one class on the specialty tier. The national average is **80%**. The conditions most likely to be subject to this type of formulary design are cancer, MS and HIV/AIDS.

An average of **23%** of brand drugs have a coinsurance of 30% or higher in the Oklahoma exchange, compared to a national average of **27%** of brand drugs having coinsurance of 30% or higher.

1 Estimated Number of Potential Marketplace Enrollees, Kaiser Family Foundation, accessed January 2016 http://kff.org/health-reform/state-indicator/marketplace-plan-selections-as-a-share-of-the-potential-marketplace-population/#
2 42 U.S.C. § 18022(b)(2).
3 Kaiser/HRET 2015.
4 Analysis by Avalere of silver plans included in the HHS landscape file and collected from all state based exchanges; Average for U.S. is based on Avalere analysis of California, Nevada, New Mexico, New York, Oregon, Hawaii and federal exchange state silver plans; Average drug deductible is based on the average of separate, non-$0 drug deductibles; employer average from Kaiser/HRET Survey of Employer-Sponsored Benefits, 2015.
5 Analysis by Avalere of benefit designs for all silver plans in the state. All plans with no cost sharing after the deductible were excluded from the analysis.
6 Analysis by Avalere of HHS Landscape File and the California and New York exchanges, November 2015.
7 Analysis by Avalere of total chemical entity submission counts by USP class covered by 2017 Essential Health Benefits (EHB) Benchmark Plans, https://www.cms.gov/cciio/resources/data-resources/ehb.html.
8 P&T requirement starting in 2017 could add additional protections for patients taking these drugs.
9 Analysis by Avalere Health of single-source brand medicines (medicines without a generic alternative on the market) across 22 classes, including immunosuppressants and classes that treat HIV, cancer, diabetes, asthma, multiple sclerosis, mental health conditions and hepatitis C; based on data collected by Managed Markets Insight & Technology, LLC.

Analytics by Avalere Health. Developed by PhRMA.